Jeffrey S. Garbis, M.D.
Jeffrey Bernstein, M.D.
Marvin E. Lawrence, II, M.D.
Priti Bijpuria, M.D.
Richard M. Chasen, M.D.
Theodore Y. Kim, M.D.
Sean M. Karp, M.D.
Eileen Erskine, C.R.N.P.

Dear New Patient:

Welcome and thank you for trusting Capital Digestive Care, LLC with your care.

The enclosed packet contains our new patient registration forms. You will need to complete all registration forms and bring the completed forms with you to your visit along with the list of items below.

We now offer an interactive online patient portal **(gPortal)** that gives you access to update your personal information, view certain test results and communicate with your physician or physician's office. If you've already supplied us with your email, you may have received an invitation to our patient portal. If you haven't already done so, we urge you to share your email address with us so we can send you an invitation.

*****BE SURE TO REVIEW BOTH FRONT AND BACK OF PACKET*****

It is very important to bring the following items to your first visit:

- ✓ **The completed Patient Information Forms, Patient History Forms & Signed Notice of Privacy Practices enclosed in this packet**
- ✓ **Insurance Card/s**
- ✓ **Picture Identification (such as a driver's license)**
- ✓ **Any recent Laboratory (blood work) results related to your visit with us**
- ✓ **Any recent Radiology results related to your visit with us. (**This might include Upper GI Testing, Barium Enema, CT Scan, or Ultrasound results.)
- ✓ **A list of your current medications with the doses and the frequency taken**
- ✓ **For HMO patients requiring a referral, a referral from your Primary Care Physician**
- ✓ **Co-payment if applicable**

If you are being referred to us for an abnormal laboratory/radiology result, it is imperative that we have a copy of these results so that we can complete your consultation without having to repeat testing.

FAILURE TO BRING THE REQUIRED DOCUMENTS MAY RESULT IN YOUR APPOINTMENT BEING RESCHEDULED.

Please note there is a $50 fee for appointments not cancelled within 48 hours.

Thank you for allowing us to participate in your medical care.
We look forward to seeing you soon. 03/09/16 gg

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PATIENT INFORMATION FORM

Date: ________________________

Patient Information:

Patient Name:	Patient Date of Birth:
Patient Address:	City, State, Zip:
Home Phone:	Work Phone:
Cell Phone:	Sex: M F
Height:	Weight:
Age:	Marital Status: Single Married Other
Social Security #:	Email Address:
Patient Employer:	Occupation:

Spouse's Information:

Spouse's Name:	Spouse's Date of Birth:
Spouse's Social Security #:	Spouse's Employer:
Spouse's Work Phone:	Spouse's Cell Phone:

Emergency Contact Information:

Emergency Contact Name and Number:

Physician Information:

Primary Care Physician:	Referring Physician:

Laurel, MD
7350 Van Dusen Rd
Suite 210 & 230
Laurel, MD 20707
301-498-5500 Office
301-498-7346 Fax

Columbia, MD
5500 Knoll North Dr.
Suite 460
Columbia, MD 21045
410-730-9363 Office
410-730-2084 Fax

Takoma Park, MD
7610 Carroll Ave
Suite 250
Takoma Park, MD 20912
301-270-3640 Office
301-270-3645 Fax

Primary Insurance:

Insurance Co. Name:	Phone #:
Address:	City, State, Zip:
Name of Policy Holder:	Social Security #:
Relationship to patient:	Date of Birth:
Insurance ID#:	Insurance Group:

Secondary Insurance:

Insurance Co. Name:	Phone#:
Address:	City, State, Zip:
Name of Policy Holder:	Social Security #:
Relationship to Patient:	Date of Birth:
Insurance ID#:	Insurance Group:

*****TO BE COMPLETED IF PATIENT IS A MINOR*****

Responsible Party:	Phone #:
Address:	City, State, Zip:
Employer:	Work Phone:

Communications Notification

Email address (please print):____

Telephone: (Home)______________________(Mobile)_____________________________

Capital Digestive Care employs a number of different resources for the purpose of contacting you to deliver important information. Your privacy is important to us and we will not share or sell your information to any third-party vendor except when required for legal and debt collection purposes. Listed below are examples of some of the reasons we may need to reach you using the information we collect at the time of registration (for new patients) or have on file (for established patients), which may include your email address, home or mobile telephone number.

- **Patient Portal Access:** If you choose to create an account, you will be able to update your personal information before or after your appointment, view certain test results and send messages to your doctor and/or doctor's office.
- **Practice Announcements:** These may include new physician or provider announcements or provider retirement/relocation notifications.
- **Customer Service Improvements:** We are always evaluating applications to improve our service to you, including solutions to improve appointment scheduling, appointment reminders and procedure preparation. As the applications become available, you may receive a notification or registration invitation.
- **Digestive Health Information:** This may include information on new treatments or clinical research trials, notification of educational seminars on specific digestive health topics or other relevant information.
- **Collection Activity:** If your account becomes delinquent, Capital Digestive Care may employ the services of a collection agency to recover any outstanding balance on your account. You may request the removal of your mobile number for this purpose by providing written notification to Capital Digestive Care, ATTN: Billing Manager, 12510 Prosperity Drive, Suite 200, Silver Spring, MD 20904.

Patient Name (please print) ____ (revised 03-10-16 gg)

Patient Signature ______________________________________**Date:** ____________________

Complete Patient History Form

Name:____Date of Birth:______________

The following information is **very important to your health**. Please take time to fully and completely fill out this important information. We are counting on you!

- **Reason for visit**____

____

Race

○ White/Caucasian	○ Black or African American	○ Asian	○ Hispanic or Latino
○ American Indian or Alaska Native	○ Native Hawaiian or Other Pacific Islander	○ Mixed	○ Other
○ Unknown	○ Patient Declines to provide information		

Ethnicity

○ Hispanic or Latino	○ Not Hispanic or Latino	○ Patient Declines to provide information

Gender

○ Male	○ Female	○ Other

Preferred Language

○ English	○ Spanish	○ Other_______________

Contact Preference

○ Letter	○ Other_______________________________

- **What pharmacy do you want us to use for any medications that are prescribed?**

Pharmacy: ____

____

Allergies

○ Patient has no known allergies	○ Patient has no known **DRUG** allergies	○ Adhesive tape	○ Codeine Sulfate
○ Erythromycin	○ Latex	○ IV Contrast	○ Penicillins
○ Sulfa	○ Shellfish	○ Other_______________	○ Other_______________

Complete Patient History Form

Name:______________________________ Date of Birth:______________

Current Medications (include any Over-the-counter medications and any supplements you are currently taking)

o None

Name Dose How taken

____

____

____

____

____

____

____

____

____

Immunizations

o None	o Flu vaccine When:______________	o Hepatitis A When:______________
o Hepatitis B When:______________	o Pneumovax When:______________	o TB Skin test When:______________

Diagnostic Studies

o None	o Colonoscopy When:______________	o Endoscopy/EGD When:______________
o CT Scan Abdomen/Pelvis When:______________	o MRI of Abdomen/Pelvis When:______________	o ERCP When:______________

Previous Procedures/Surgeries

o None	o Gallbladder removed	o Appendectomy	o Colon resection	o Small Bowel resection
o Exploratory Abdominal Surgery	o Gastric Bypass Surgery	o Lap Band Surgery	o Hemorrhoid Surgery	o Hemorrhoid Banding
o Abdominoplasty	o Hysterectomy	o Tubal Ligation	o Mastectomy	o Pacemaker Placement
o Defibrillator Placement	o Coronary Artery Bypass Graphing (CABG)	o Abdominal Aortic Aneurysm (AAA) Repair	o Heart Valve Replacement /Surgery	o Cardiac Catherization /Stent
o Joint Replacement	o Back Surgery	Other______________		Other______________

Complete Patient History Form

Name:____ Date of Birth:________________

Past or Present Medical History

- **Gastroenterology/Hepatology**

○ Colon polyps	○ Colon cancer	○ Irritable Bowel Syndrome	○ Diverticulitis
○ Crohn's Disease	○ Ulcerative Colitis	○ GERD /Reflux	○ Barrett's Esophagus
○ Ulcer Disease	○ Hepatitis B	○ Hepatitis C	○ Fatty Liver Disease
○ Cirrhosis/Liver	○ Celiac Disease	○ Bowel Obstruction	○ Pancreatitis
○ Anemia in the past	○ Other __________	○ Other __________	○ Other __________

- **Cardiology**

○ Coronary Heart Disease	○ Heart Valve Disease	○ Congestive Heart Failure	○ Heart attack
○ High Blood Pressure	○ Atrial Fibrillation	○ Vascular Disease	○ High Cholesterol
○ Stroke	○ TIA (mini stroke)	○ Other ____________________	

- **Pulmonary**

○ C.O.P.D.	○ Asthma	○ Sleep Apnea
○ Blood Clots (leg)	○ Blood Clots (lung)	

- **Other**

○ Anxiety Disorder	○ Arthritis	○ Bipolar Disorder	○ Body Piercings
○ Breast Cancer	○ Current Pregnancy	○ Depression	○ Diabetes
○ Fibromyalgia	○ Gout	○ HIV Exposure	○ HIV Infection
○ Hypothyroidism	○ Kidney Disease	○ Kidney Stones	○ Lung Cancer
○ Ovarian Cancer	○ Other Cancer	○ Prostate Cancer	○ Recurrent Infections
○ Seizures	○ Skin Cancer	○ Tattoos	Other__________

Complete Patient History Form

Name:______________________________ Date of Birth:____________

Social History

○ Single	○ Married	○ Divorced	○ Separated
○ Widowed	○ Civil Union	○ Unknown	○ Other

I drink alcohol:	**I drink caffeine:**	**I use tobacco:**	**My drug use:**	**I exercise:**
____None _____Less than 7 per week _____More than 7 per week	(coffee, tea, cola, or other caffeinated drinks) _____None _____Occasionally _____Daily	(Circle) Cigarettes Cigars Chewing tobacco __Every Day __Only some days __Former smoker __Never smoked __Smoker, Current status unknown __Unknown if ever smoked	_____None _____IV or inter-nasal drugs **currently** _____IV or inter-nasal drugs **in the past**	___None ___I exercise routinely

Family History

- ○ No knowledge of family history
- ○ **No one in my family has a history of**:

○ Celiac Sprue	○ Colon polyps	○ Gallbladder Disease
○ Liver Disease	○ Stomach Cancer	○ Colon Cancer
○ Crohn's Disease	○ Inflammatory Bowel Disease	○ Polyps
○ Ulcerative Colitis		

- ○ **Someone in my family has a history of**: (please check all that apply)

	Mother	**Father**	**Sister**	**Brother**	**Grandmother**	**Grandfather**
Colon Cancer						
Colon Polyps						
Crohn's Disease						
Gallbladder Disease						
Liver Disease						
Ulcerative Colitis						
Stomach Cancer						

Complete Patient History Form

Name:______________________________ Date of Birth:______________

Review of Systems....What are your current symptoms today? (check all that apply):

Allergic/Immunologic
- allergic reactions ○
- current infections ○

Cardiovascular
- chest pain ○
- irregular heart beat ○
- rapid heart rate/palpitations ○
- ankle swelling ○

Constitutional
- fever ○
- loss of appetite ○
- weight loss ○

ENMT
- nose bleeds ○
- loss of vision ○
- hoarseness ○
- mouth sores ○

Endocrine
- excessive thirst ○
- heat or cold intolerance ○

Gastrointestinal
- abdominal pain ○
- abdominal swelling ○
- change in bowel habits ○
- constipation ○
- diarrhea ○
- gas ○
- heartburn ○
- nausea ○
- rectal bleeding ○
- stomach cramps ○
- vomiting ○
- difficulty swallowing ○
- yellowing of skin ○

Genitourinary
- blood in urine ○
- recent darkening of urine ○

Hematologic/Lymphatic
- easy bruising ○
- anemia ○

Integumentary
- itching ○
- rashes ○
- rashes/hives ○

Musculoskeletal
- back pain ○
- joint pain/arthritis ○

Neurological
- dizziness ○
- fainting ○
- frequent headaches ○
- vertigo ○
- memory loss/confusion ○

Psychiatric
- depression ○
- anxiety/panic attacks ○

Respiratory
- wheezing ○
- frequent cough ○
- shortness of breath when at rest ○

CAPITAL DIGESTIVE CARE™
First in Digestive Health

Laurel, MD Takoma Park, MD Columbia, MD

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you may obtain access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice up on request

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Example of Treatment, Payment and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians and other members of your treatment team will record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to authorized family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you for fundraising purposes, but you have the right to opt out of receiving such communications.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related tor ecalls of dangerous products, and similar information to public health authorities.

Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Business Associates: We may disclose your health information to business associates or third parties that we have contracted with to perform agreed upon services.

We do not engage in selling your health information, however if we do, we will obtain your written authorization before we are permitted to sell your health information. In all other situations, including marketing activities, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to restrict disclosures of your health information to your health plan for payment and health care operations purposes (and not for treatment) if the disclosure pertains to a health care item or service for which you paid out-of-pocket in full. If requesting a restriction for a health care item or service for which you paid out-of-pocket in full, we will honor your request, unless the disclosure is necessary for your treatment or is required by law. For all other restriction requests, we are not required to agree to such restrictions, but, if we do agree, we must abide by those restrictions.

Confidential Communication: You may ask us to communicate with you confidentially by for example, sending notices to a special address or not using post-cards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or, important information is missing, you have the right to request that we correct the existing information or add the missing information.

Accounting or Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment payment, or health care options.

Breach Notification: We are required to notify you in the event of a breach of your unsecured protected health information, and will do so

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or, you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints,
Please contact:

The Privacy Officer
7350 Van Dusen Road
Suite 210
Laurel, MD 20707
(301) 498-5500

I ____
hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed ________________________ Date:

If not signed, reason why acknowledgement was not obtained:

Staff Witness seeking acknowledgement:

Date:

There's a new way to communicate with your doctor and their office.

In addition to calling us during regular business hours, we now have an online patient portal that allows you 24/7 access from anywhere.

gPortal will allow you to

- Send messages to your doctor or their staff (all messages left will be processed the next business day)
- Request appointments
- Check your laboratory results
- Request prescription refills
- Update your personal and medical records

If you are interested in signing up for our gPortal, please complete the information below and an invitation will be emailed to you. **Your emailed invitation will be titled "Myportal-no reply with Capital Digestive Care in the subject." Be sure to check your spam and junk email for the invitation. If you don't receive your invitation within a couple days let us know and we'll resend it.**

Name: ____

Date of Birth: ____

Email Address: ____

Date: ____

Be sure to ask a staff member for a gPortal brochure. We look forward to communicating with you online.

03-10-16 gg

Benefits

With gPortal, you can...

- Request appointments
- Check your results
- Send a message to our practice
- Update your personal and medical records
- Log-on 24/7- access from anywhere

gPortal, the link between you and our practice

How to Start...

Recommended for
Internet Explorer (8 or higher), or Mozilla-Firefox.

Create
your username and password
today!

Start **taking an active role** in your healthcare!

Contact...

CAPITAL DIGESTIVE CARE℠
First in Digestive Health

Maryland Digestive Disease Center
Laurel, MD
Columbia, MD
Takoma Park, MD
301-498-5500

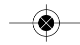
Now we have an interactive **online portal** designed **specifically for you,** our valued **patient**

Introducing...

by

Capital Digestive Care

! If you need immediate medical attention, please call 911 or go to your nearest hospital.



How do I register?

Step 1: You will receive an invitation email from our practice with a link and unique ID that will take you through the registration process.

Step 2: Click on the link in the invitation email to create a unique user ID and password.

New account registration

Tell us about yourself.

First name

Last name

Please enter your first and last name the same way as you are registered at our practice.

Date of birth

Portal PIN number

Registration on our patient portal is open only to our patients and requires a PIN number. Patients may contact us to obtain a PIN number.

Create your login.

Username

Username must be at least 2 characters. Spaces are not allowed.

Password

Confirm password

Your password must be at least 5 characters and be strong strength (all three types of characters: letters, numbers and punctuation). Passwords are case sensitive.

Security question

Security question answer

The answer has to have at least 2 characters.

Accept the terms of use.

Step 3: Once registered, complete your medical, family and social history.

You may send a message directly to our practice to update additional fields (ex. Address, Insurance information, etc).

Step 4: Click submit to send your information directly to our office

How do I...

Send a message to my Doctor's office?

- Click on the message tab.
- Click "new" and compose your message.
- Remember to hit send.

Receive messages through gPortal?

- You will receive a notification email when you have a message waiting in ***gPortal***.
- Click on the message tab.
- Click on "new messages" to view your messages.

Update my personal information?

- Click "update" button.
- Click on the "personal info" tab.
- Change the information you want

How do I...

Reset my password?

- Click on the "change password" tab.
- Enter username, DOB and registered email address.

Frequently Asked Questions

Q: Can I schedule my appointment online through gPortal?

A: You may send a request to schedule your appointment and our practice will contact you.

Q: Does gPortal allow me to send a message directly to my physicians office?

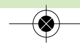
A: Yes, you may send a message directly to our office through gPortal. We will make sure your message reaches the correct person so that your question is answered.

Q: Can I refill my prescriptions through gPortal?

A: No, you must go directly through your pharmacy in order to refill your prescription.

Q: What do I do if my account is locked due to too many failed log-in attempts?

A: Click on the change password tab and follow the instructions to create a new password.



TELEPHONE CALLS

If you wish to speak to your physician by telephone, please leave a message with our staff and your physician will return your call. Except for emergencies, calls may not be returned until after office hours.

BILLING AND INSURANCE

As a courtesy to our patients, we will file all necessary insurance forms to bill for services rendered. If payment is not received in thirty days from your carrier, it will be your responsibility to call your insurance company to facilitate payment. **It is also the patient's responsibility to ensure that all HMO referrals are valid and on file with the billing office. No exceptions will be made for HMO patients who do not have a referral on file.**

We participate with most insurance companies. We also accept all major credit cards.

Our Centralized Billing Office can assist you between the hours of 8:00 a.m. to 4:00 p.m. Monday through Friday. Please call 866-331-4232, option 2.

LOCATIONS

Laurel Medical Arts Pavilion
7350 Van Dusen Road
Suite 210
Business Office: Suite 250
Laurel, MD 20707
Tel 301-498-5500
Fax 301-498-7346

7610 Professional Building
7610 Carroll Avenue
Suite 250
Takoma Park, MD 20912
Tel 301-270-3640
Fax 301-270-3645

Columbia Medical Campus
5500 Knoll North Drive
Suite 460
Columbia, MD 21045
Tel 410-730-9363
Fax 410-730-2084

please visit us on the Web at:
www.capitaldigestivecare.com/MDD

Maryland Digestive Disease Center

Gastroenterology

JEFFREY S. GARBIS, M.D., F.A.C.G.

RICHARD M. CHASEN, M.D., F.A.C.G.

JEFFREY BERNSTEIN, M.D., F.A.C.G.

THEODORE Y. KIM, M.D., F.A.C.G.

MARVIN E. LAWRENCE II, M.D., F.A.C.G.

SEAN M. KARP, M.D., F.A.C.G.

PRITI BIJPURIA, M.D.

www.capitaldigestivecare.com/MDD

Welcome to our Medical Practice

INTRODUCTION

This booklet is designed to answer questions and provide information regarding our medical practice and office policies. We strive to provide patient satisfaction with high quality medical services in a relaxed atmosphere with teams of qualified personnel to assist you.

HOSPITALS

All physicians of Maryland Digestive Disease Center are Board Certified and have privileges at the following hospitals: ***Laurel Regional, Washington Adventist, and Howard County General.*** Unfortunately, we are unable to treat patients who are admitted to other hospitals in the area.

OFFICE HOURS

Our telephone hours are Monday through Friday 8:30 a.m. to 5:00 p.m. Office hours vary from location to location. Please call ahead if you plan on visiting an office without a scheduled appointment.

PATIENT APPOINTMENTS

We have three locations in which our physicians see patients. When making an appointment, please call 301-498-5500. If you need to be seen by your physician on an emergency basis, you may have to travel to an alternate location depending on appointment availability. We strive to see our patients as soon as possible to facilitate treatment.

If your appointment is for an initial office visit, our registration paperwork can be downloaded from our website at www.capitaldigestivecare.com/mdd or, if preferred, can be mailed to you upon request. Please bring your completed registration paperwork with you on the date of your visit. Insurance cards and picture ID's are collected at every visit. We also request that you bring all recent laboratory work, scans and x-rays related to your initial visit.

If you are a HMO patient, you must bring your referral form from your primary care physician. Also, please be prepared to pay your copayment at time of visit.

If you need to cancel an appointment, we require that you notify us 48 hours before your appointment. We reserve the right to charge for appointments canceled or broken without 48 hours advance notice.

Occasionally, hospital emergencies will result in a change in your appointment. We will notify you as soon as possible when this situation arises.

EMERGENCY CARE

For after hour needs, we employ a qualified answering service to assist you in connecting with the physician on call for emergencies only. The answering service can be reached at **240-790-1625**. All non-emergency calls should be placed during regular office hours.

PRESCRIPTIONS AND REFILLS

All prescriptions and refills should be requested during regular office hours allowing up to 72 hours to process your request. Please have your pharmacy fax or call us for refills.

Discover a New Standard for Your Digestive Health

DIRECTIONS TO OUR THREE LOCATIONS:

Laurel Office:
Laurel Medical Arts Pavilion
7350 Van Dusen Rd.
Suites 210 and 230
Laurel, MD 20707
Telephone: 301-498-5500
Fax: 301-498-7346
Business Office: Suite 250

From the South:
- Take I-95 North toward Baltimore
- Take exit 33A, which is Laurel Route 198.
- As you exit off ramp, stay in your far right lane.
- At intersection make right turn onto Van Dusen Road.
- Stay straight on Van Dusen.
- At 5th traffic light turn right into Laurel Regional Hospital's driveway. Our building sits to the right of of the hospital.

Takoma Park Office:
7610 Professional Building
7610 Carroll Ave.
Suite 250
Takoma Park, MD 20912
Telephone: 301-270-3640
Fax: 301-270-3645

From the North:
- Take I-95 South toward Washington to 495 toward Silver Spring
- Take exit 29-B University Blvd/Langley Park.
- Follow University Blvd., to Carroll Ave.
- Make a right on to Carroll Avenue.
- Go through the 1st traffic light and make a right into Washington Adventist Hospital Parking lot. Our building is to the immediate left.

Columbia Office:
Columbia Medical Campus
5500 Knoll North Drive
Suite 460
Columbia, MD 21045
Telephone: 410-730-9363
Fax: 410-730-2084

From 29 North or South:
- Take Exit 175 East (Exit 20A) toward Jessup
- Take first left at Thunderhill Road.
- Take the first left onto Lightening View.
- Take the first left onto Knoll North Drive.
- Our building is on the left.

From I-95 North or South:
- Exit onto 175 West (exit 41B) toward Columbia
- Keep left at the fork to continue onto 175W
- Approximately 4.5 miles turn right onto Thunderhill Rd.
- Make first left onto Lightening View.
- Make first left onto Knoll North Drive
- Our building is on the left.

(revised 3/10/16/gg)